



CONFIDENTIAL * CASE REVIEW FORM

To be completed by person initiating case review requests:

Name: _____ Title/Cert#: _____
 Employer: _____ Phone: _____
 Address: _____ Today's Date: ____/____/____
 Date of Occurrence: ____/____/____ Time: _____ Run#: _____
 Location: _____
 Base Hospital: _____ Receiving Hospital: _____

Persons Involved:	Notified of Report:	Employer Notified:
_____	() Yes No ()	() Yes No ()
_____	() Yes No ()	() Yes No ()
_____	() Yes No ()	() Yes No ()

If yes, name of person notified: _____

Brief description of occurrence: _____

Notification of:

- | | |
|---|--|
| () Exceptional Performance | () Deviation of Destination Guidelines |
| () Educational | () Equipment malfunction (not communications) |
| () Deviation from policy/protocol | () Physician on scene |
| () Medication error | () Scope of Practice |
| () Controlled substance | () Dispatch |
| () Lost () Broken () Defective | () Other (explain below) |

Referred Case Review Request to: _____ Date: ____/____/____

REVIEWER'S USE ONLY

Name: _____ Title: _____ Date: ____/____/____
 Employer: _____ Address: _____
 Phone: _____ Run Report#: _____ Log #: _____

DO NOT PLACE IN PATIENT RECORDS



COMMUNICATION FAILURE FORM

This form is to be completed whenever Base Hospital radio or telephone contact cannot be established or maintained. A verbal report must be made to the MICN or Base Hospital Physician immediately upon voice contact. DO NOT USE THIS FORM IF Base Hospital contact was made after prior to contact procedures were performed.

Report initiated by _____	Title/Cert# _____	Unit# _____
Employer _____	Address _____	
Phone _____	Date of Report <u> </u> / <u> </u> / <u> </u>	Date of RCF <u> </u> / <u> </u> / <u> </u>

Prior to contact skills performed: ☐ Yes ☐ No

Prior to contact skills performed: _____

List RCF procedures performed: _____

Summary of situation, patient assessment and treatment: _____ (Use additional pages if needed)

Relative to what patient care protocol?: _____

Type of Radio: _____ Base Hospital: _____

Receiving Hospital: _____ Patient report given to: _____

Probable cause of failure: _____

Signature: _____

A photocopy of the completed **PATIENT CARE RECORD MUST ACCOMPANY THIS FORM**, and both submitted to the Base Hospital within 24 hours following Communication Failure for review by the Base Hospital Physician. A copy of the Patient Care Record and RCF form may be required by your Agency's Paramedic Coordinator for review. Consult your employer regarding patient confidentiality.

*****DO NOT PLACE IN PATIENT RECORD*****

REVIEWER'S USE ONLY

Reviewed by:	Date:
BH Physician: _____	<u> </u> / <u> </u> / <u> </u>
PLN: _____	<u> </u> / <u> </u> / <u> </u>
PC: _____	<u> </u> / <u> </u> / <u> </u>
RCF Form Rcv'd: _____	<u> </u> / <u> </u> / <u> </u>
Review completed: _____	<u> </u> / <u> </u> / <u> </u>

LOG # _____